STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964659	**01/06/2016**
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **906 36TH STREET** **WEST PALM BEACH, FL 33407**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 Initial Comments

An unannounced abbreviated relicensure survey was conducted on 01/06/2016 at B P Assisted Living. The facility had deficiencies at the time of the visit.

0026 Resident Care - Social & Leisure Activities

Based on observations and interviews the facility failed to provide and encourage social, recreational, educational and other activities within the facility and the community for 2 of 3 sampled residents (Resident #2 and Resident #3).

The Findings included:

On / at 8:25 AM, the surveyors entered the facility. This surveyor noticed two residents sitting in recliners in the den area watching TV.

On / at 8:56 AM , a tour was conducted of the facility. This surveyor observed Resident # 2 and Resident # 3 sitting in recliner chairs in the den of the facility.

On the same day at 10:32 AM, an interview was conducted with Resident # 3. She revealed that they have not had any activities for several months. She says she does like to play a card game called Bidwisk.

On / / at 1:45 PM, an interview was conducted with the Administrator. She confirmed that they had not conducted any group actives in the past 4 months.

On / / at 1:50 PM, an observation was made of Resident # 2 and 3 still sitting in the same chairs as observed at 8:25 AM They were only seen out of the chairs at 12:00 PM eating lunch at the dining table.

Class III

0030 Resident Care - Rights & Facility Procedures

Based on observation and interview, it was determined the facility failed to ensure that the statewide toll-free telephone number of the Florida Hotline was posted in close proximity to a telephone accessible by residents and was in a minimum of 14-point font.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964659	01/06/2016
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **906 36TH STREET** **WEST PALM BEACH, FL 33407**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The Findings included:

During observation of the facility and interview with the Administrator, conducted on 01/06/2016 beginning at approximately 9:15 AM, she was asked where the statewide toll-free telephone number for the Florida Hotline was posted. The bulletin board with advocacy numbers was reviewed at this time. The Florida Hotline number was not located. The Administrator stated she was not aware of the requirement to post this number.

Class

0054 Medication - Records

Based on interview, observation, and record review, it was determined the facility documented the provision of medication on the MOR (Medication Observation Record) which the medication was not in the facility, for 1 of 3 sampled resident records reviewed (Resident #3).

The Findings included:

During reconciliation of the medications conducted on / beginning at approximately 10:00 AM with the Administrator and 2 surveyors, the Administrator was asked where the , ( ) 15mg tablets were located for Resident #3. She replied that all of Resident #3's medications are pre-packaged by the pharmacy. At the time of this interview, observation, and record review the Administrator was provided the opportunity to locate the ( ) 15mg tablets and she was not able to do so. She acknowledged that the LPN (Licensed Practical Nurse) had been signing as having provided this medication at 6:00 PM daily from / - . The Administrator also acknowledged that Resident #3's health assessment (dated) notes ( ) 15mg is to be provided orally at bedtime on a daily basis. The Administrator could not provide an explanation as to why the LPN had been signing as having provided this medication to this resident as it was not located in the locked medication cabinet with all of this resident's other medications.

Class III

0055 Medication - Storage and Disposal

Based on observation and interview the facility, failed to store medication in a secure manner, specifically related to ensuring that keys are only accessible to the staff responsible for medication assistance to residents.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964659	01/06/2016
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **906 36TH STREET** **WEST PALM BEACH, FL 33407**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

The Findings included:

On 01/06/16 at 9:12 AM, a tour was conducted of the facility. During this tour, an observation of the facility medication storage cabinet revealed the keys on top of the counter near the kitchen cabinet, (standard counter size) easily accessible to residents and/or visitors.

On the same day an interview was conducted with the facility Administrator who stated the keys are left on the counter. She also confirmed that none of the staff carried the keys somewhere on their person while working in the facility. She acknowledged that this was not a good practice since Resident # 3 ambulates without assistance and could have easy access to the medication. She stated she would begin a new practice of requiring staff to hold the keys for safety.

Class III

0078 Staffing Standards - Staff

Based on interview and record review, it was determined the facility failed to ensure all staff members had documentation within their personnel file indicating freedom from ( ), for 3 of 4 sampled Staff (Staff A, B and C).

The Findings included:

a) Review of Staff A's personnel file revealed a date of hire noted as . The last documented physician statement indicating freedom of communicable (including) was documented as / / . The file contained no further documentation indicating freedom of .

b) Review of Staff B's personnel file revealed a date of hire noted as / .) The last documented physician statement indicating freedom of communicable (including) was documented as . The file contained no further documentation indicating freedom of .

c) Review of Staff C's personnel file revealed a date of hire noted as did not have any documentation of an annual negative examination. The last documented physician statement indicating freedom of communicable (including) was documented as / . The file contained no further documentation indicating freedom of since aforementioned dated.

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964659	01/06/2016
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **906 36TH STREET** **WEST PALM BEACH, FL 33407**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

On 01/06/16 at 1:11 PM, an interview was conducted with the facility Administrator. She acknowledged that the above noted staff members did not have the required annual statements on file.

Class III

0093 Food Service - Dietary Standards

Based on interview and record review, it was determined the facility failed to prepare and served therapeutic diets as ordered by the health care provider, for 1 of 3 sampled residents (Resident #3). In addition, based on observation, interview, and record review, it was determined the facility did not maintain a sufficient supply of nonperishable foods on hand at all times, specifically related to disaster menu supplies for a census of 3 sampled residents (Residents #1, #2, and #3).

The findings include:

1) During entrance conference conducted with the Administrator on / beginning at approximately 9:00 AM, she was asked if the facility has any residents receiving a therapeutic diet (i.e. puree, mechanical soft, no added salt, etc.). The Administrator stated that all 3 current resident received a regular diet and that there are no therapeutic diets at this time. She confirmed that she is the food service designee for the facility at this time, as well.

During interview and record review for Resident #3 (who is receiving hospice services), conducted with the Administrator on / beginning at approximately 11:15 AM, her health assessment (dated) indicated she is to receive a puree diet with nectar thickened liquids. Resident #3's Hospice Certification and Plan of Care, dated /, also reflected she is to receive a puree diet with nectar thickened liquids. The Administrator and Staff A (direct care staff that was preparing lunch at this time) were asked what type of diet Resident #3 receives. The Administrator stated a regular diet. Staff A stated that she actually chops up her food for her into smaller bites. The Administrator was asked why the health care provider's orders for a puree diet with nectar thickened liquids was not followed. She stated she was not aware of those orders. The Administrator subsequently obtained a clarification order from Resident #3's hospice physician that indicated she is to receive a mechanical soft diet as tolerated and thin liquids as tolerated (discontinue the puree diet and discontinue thickened liquids). The Administrator acknowledged that the facility had not been following the previous health care provider's diet orders for Resident #3 that noted a puree diet with nectar thickened liquids since .

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964659	**01/06/2016**
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **906 36TH STREET WEST PALM BEACH, FL 33407**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

2) During observation of the facility's disaster supplies; review of disaster menu; and interview with the Administrator conducted on / beginning at approximately 11:30 AM the posted disaster menu indicated the facility is to have on hand the following items and they were not present in the facility:
a) canned corned beef
b) canned tuna
c) canned beef stew
d) canned chicken
e) canned ravioli
f) caned chicken and dumplings
g) canned potatoes
h) canned carrots
i) canned sweet potatoes
j) canned peas
k) canned three bean salad
l) canned pineapple
m) canned peaches

The only non-perishable protein on hand was 1 can of pink salmon and 2 jars of peanut butter (neither of which were on the disaster menu provided and signed by the Registered Dietitian and 1 of the jars of peanut butter expired 3 months ago). The only canned vegetables on hand was 1 can of green beans and 1 can of beets. The only canned fruit on hand was a large can of fruit cocktails (which was not noted on the disaster menu provided and signed by the Registered Dietitian). The Administrator was asked where the items noted on the disaster menu were located. She stated staff must have utilized them and not replaced them or informed her that they had been utilized so she could replace them.

Class III

0162 Records - Resident

Based on interview and record review it was determined the facility failed to establish an interdisciplinary care plan per 58A-5.0181, F. A. C. for 1 of 1 hospice resident records reviewed (Resident #3).

The Findings included:

During interview and record review for Resident #3 conducted with the Administrator on / beginning at approximately 11:15 AM, this resident's hospice Initial Integrated Plan of Care was reviewed. This plan of care was dated / and the Administrator acknowledged it only reflected the hospice nurse is to coordinate the Plan of Care with facility staff. This document did not reflect what

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11964659	**01/06/2016**
NAME OF PROVIDER OR SUPPLIER **B P ASSISTED LIVING**	STREET ADDRESS, CITY, STATE, ZIP CODE **906 36TH STREET** **WEST PALM BEACH, FL 33407**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

goals and interventions the facility staff is responsible for nor what goals and interventions the hospice staff is responsible for. The Administrator also acknowledged that the Hospice Certification and Plan of Care, dated / /2015, only noted that a nursing plan of care will be established that meets the patient's needs. The Administrator stated she was not aware of the requirement that there needed to be an interdisciplinary care plan for a resident receiving hospice services.

Class III

RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

, 2016

Administrator
B P Assisted Living
906 36th Street
West Palm Beach, FL 33407

Dear Administrator:

This letter reports the findings of a state licensure survey that was conducted on , 2016 by representative(s) of this office.

Attached is the provider's copy of the State (5000-3547) Form, which indicates the deficiencies that were identified on the day of the visit. Section 408.811(4), Florida Statutes, requires that you correct these deficiencies within thirty days of the date of this letter unless the Agency has approved another timeframe. **Please attach a summary of your corrective action for each deficiency, including completion dates, on your letterhead. Also include any additional documentation to support correction of identified deficiencies. Submit summary and documents to the Field Office no later than , 2016.** Staff from this office will conduct a review of the provided corrective action and supporting documentation to verify that the necessary corrections are in place to correct the deficiencies identified on your survey, which may include a desk review or onsite revisit.

The Quality Assurance Questionnaire has long been employed to obtain your feedback following survey activity. This form has been placed on the Agency's website at http://ahca.myflorida.com/Publications/Forms.shtml as a first step in providing a web-based interactive consumer satisfaction survey system. You may access the questionnaire through the link under Health Facilities and Providers on this page. Your feedback is encouraged and valued, as our goal is to ensure the professional and consistent application of the survey process.

Thank you for the assistance provided to the representative. Should you have any questions please call this office at (561) 381-5840.

Sincerely,

Arlene Mayo-Davis
Field Office Manager

AMD/dso
Enclosure
XG90

Delray Beach Field Office
5150 Linton Boulevard, Suite 500
Delray Beach, FL 33484
Phone:(561) 381-5840; Fax:(561) 496-5924
AHCA.MyFlorida.com